

**1-800-562-6078**

**INCIDENT DESCRIPTION WORKSHEET**

Please answer the following questions to the best of your ability. Specific details will help in providing a more complete report. Use the blank column on the right to note your responses. Use of this worksheet is optional.

**GENERAL INFORMATION**

Reporter's first & last name (spell) & job title:	
Facility name/type of facility/address/phone:	
Alleged- Provide information for each resident/client, one at a time for <b>All</b> residents/persons involved: Spell first/last name with middle initial/gender/DOB/ADSA ID (if known):	
Diagnosis: (for each resident:	
Select # that corresponds with each resident's cognitive skills & decision making ability.	1 = Consistent & reasonable 2 = Some difficulty in new situations 3 = Poor & requires cues 4 = Rarely/never makes 5 = Unknown
Select # that corresponds with level of staff help for each resident's walking status.	1 = No help or oversight 2 = Verbal encouragement/cues 3 = Hands-on assistance 4 = Weight-bearing support 5 = Performs activity for resident 6 = Unknown
Select # that corresponds with level of staff help for each resident's transfer status.	1 = No help or oversight 2 = Verbal encouragement/cues 3 = Hands-on assistance 4 = Weight-bearing support 5 = Performs activity for resident 6 = Unknown
Date and time of incident:	
Date & time incident first reported to supervisors:	
MD/Responsible Party Notified:	
Sexual:	
Describe incident/ allegation/ circumstances/ location:	
If the incident is a pattern of behavior, describe the behavior & how often it happens; or isolated incident?	
Witnesses:	
Is the resident his or her own responsible party?	

**FALLS**

Fall preventions at time of incident:	
Fall result in injury? Describe Injuries: size/shape/color/location (if applicable):	
Similar injuries in last 3 months?	
Treatment/additional care (if applicable):	
Describe any psychological harm experienced by the resident/client.	
Action taken to prevent recurrences:	

STAFF		
Staff involved:		
Measures to notify staff of care plan changes:		
Care plan followed (at time of incident) or care plan changes:		
Alleged Perpetrator /Title/license/certification/registered:		
Staff DOB/Date of Hire/SSN		
Previous warnings/incidents (conduct with residents):		
Describe Injuries: size/shape/color/location (if applicable):		
Treatment/additional care (if applicable):		
Describe the psychological harm experienced by the resident.		
Action Taken (include dates if applicable):		
Action taken to prevent recurrences:		
Additional agencies/LLE/Fire Dept./Medical Examiner/case number:		
EXPLOITATION		
Describe exploitation/dollar amount/location/victim's access to secure valuables:		
Victim reimbursed/if not why:		
MEDICATION ERROR		
Describe Error/when discovered/including meds/dosages:		
Negative outcome to resident/client(s):		
Treatment/additional care (if applicable):		
Other pertinent information not previously stated:		
OTHER		
Select the number that corresponds with the type of incident:	1 = Unexpected resident death 2 = Disease outbreak 3 = Fire	4 = Weather-related 5 = Building Maintenance 6 = All Other
How many residents/clients are currently impacted/how long has this issue has been ongoing		
Describe the actions planned or taken to correct the issue.		
MISSING RESIDENT		
Date/time when it was discovered the resident/client was missing or had eloped.		
Is the resident his or her own responsible party?		
Does the resident have a history of exit seeking? If so, what interventions were in place?		
How long was the resident missing?		
Date/time when and how returned.		
Describe Injuries: size/shape/color/location (if applicable):		
Treatment/additional care (if applicable):		